WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

MEDICAID

Traumatic Brain Injury Waiver Services
Prior Authorization Cover Sheet

Agency Name: _____

Agency Address: _____

Provider Number: _____

Contact Person: _____

Telephone Number: (__ __ __)__ __ __-__ __ __ __

Program
Participant's Name: _____
Medicaid Number: _____

Submission Date ____/_____/_____

	Total Units per month Previously approved	Total Units Requesting per month	Service Period for this request	Total Number of Units for this period
Case Management **T1016UB**			**FROM:** **TO:**	
Personal Attendant Services **Traditional Model S5125UB** **Personal Options Model S5125 UC**			**FROM:** **TO:**	
Non-Medical Transportation **Traditional Model A0160UB** **Personal Options Model A0160 U2**			**FROM:** **TO:**	

Submit to: APS Healthcare, Inc. at 1.866.607.9903

Please note:
If form is not correctly completed, it will be returned for completion, please submit the information listed below:

I. A copy of this cover sheet;
II. A copy of signed Person-Centered Service Plan;
III. A copy of the Person-Centered Assessment; and
IV. Any other information that you feel will help justify your request.

Note: UB codes used for Traditional Service Model and UC/U2 codes used for Personal Option Service Model T1016 UB Case Management used for both Models